

1 KAMALA D. HARRIS
Attorney General of California
2 DIANN SOKOLOFF
Supervising Deputy Attorney General
3 KIM M. SETTLES
Deputy Attorney General
4 State Bar No. 116945
1515 Clay Street, 20th Floor
5 P.O. Box 70550
Oakland, CA 94612-0550
6 Telephone: (510) 622-2138
Facsimile: (510) 622-2270
7 *Attorneys for Complainant*

8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. *2013-835*

13 **SHARON MARIE BARSTOW,**
14 **aka SHARON GRANT BARSTOW**
15 **147 AB Porter Road**
16 **Pineville, LA 71360**

A C C U S A T I O N

Registered Nurse License No. 576212

Respondent.

17 Complainant alleges:

18 **PARTIES**

19 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
20 official capacity as the Executive Officer of the Board of Registered Nursing, Department of
21 Consumer Affairs.

22 2. On or about January 22, 2001, the Board of Registered Nursing issued Registered
23 Nurse License Number 576212 to Sharon Barstow (Respondent). The Registered Nurse License
24 expired on February 28, 2007, and has not been renewed.

25 **JURISDICTION**

26 3. This Accusation is brought before the Board of Registered Nursing (Board),
27 Department of Consumer Affairs, under the authority of the following laws. All section
28 references are to the Business and Professions Code unless otherwise indicated.

1 4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent
2 part, that the Board may discipline any licensee, including a licensee holding a temporary or an
3 inactive license, for any reason provided in Article 3 (commencing with section 2750) of the
4 Nursing Practice Act.

5 5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license
6 shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the
7 licensee or to render a decision imposing discipline on the license.

8 6. Section 118, subdivision (b), of the Code provides that the expiration of a license
9 shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period
10 within which the license may be renewed, restored, reissued or reinstated.

11 **STATUTORY/REGULATORY PROVISIONS**

12 7. Section 2761 of the Code states:

13 "The board may take disciplinary action against a certified or licensed nurse or deny an
14 application for a certificate or license for any of the following:

15 "(a) Unprofessional conduct, which includes, but is not limited to, the following:

16 "(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing
17 functions.

18 ...

19 "(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action
20 against a health care professional license or certificate by another state or territory of the United
21 States, by any other government agency, or by another California health care professional
22 licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that
23 action."

24 8. Section 2762 of the Code states:

25 "In addition to other acts constituting unprofessional conduct within the meaning of this
26 chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this
27 chapter to do any of the following:

28 "(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed

1 physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or
2 administer to another, any controlled substance as defined in Division 10 (commencing with
3 Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as
4 defined in Section 4022.

5 ...
6 "(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any
7 hospital, patient, or other record pertaining to the substances described in subdivision (a) of this
8 section."

9 9. California Code of Regulations, title 16, section 1444, states:

10 "A conviction or act shall be considered to be substantially related to the qualifications,
11 functions or duties of a registered nurse if to a substantial degree it evidences the present or
12 potential unfitness of a registered nurse to practice in a manner consistent with the public health,
13 safety, or welfare. Such acts shall include dishonesty, fraud, or deceit.

14 COST RECOVERY

15 10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
16 administrative law judge to direct a licentiate found to have committed a violation or violations of
17 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
18 enforcement of the case, with failure of the licentiate to comply subjecting the license to not being
19 renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be
20 included in a stipulated settlement.

21 DRUGS

22 11. Tylenol PM is an over-the-counter medication designed to help relieve pain, lower
23 fever, and make it easier to sleep.

24 12. Percocet (brand name "Oxycodone") is used to relieve moderate to severe pain. It is
25 a Schedule II controlled substance pursuant to Health and Safety Code section 1055, subdivision
26 (b)(1)(m) and a dangerous drug under Code section 4022.

27 13. Chlordiazepoxide (trade name "Librium") is used to relieve anxiety. It is a Schedule
28 IV controlled substance as designated by Health and Safety Code section 11057, subdivision

(d)(5), and a dangerous drug under Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Out of State Discipline)

14. Respondent has subjected her license to disciplinary action under Code section 2761, subdivision (a)(4), in that on or about March 13, 2012, in a disciplinary action before the Louisiana Board of Nursing (Louisiana Board) entitled *In the Matter of the Accusation Against: Sharon Marie Barstow, aka Sharon Grant Barstow*, the Louisiana Board entered a Consent Order suspending Respondent's Louisiana registered nurse license, effective February 29, 2012, and to continue the license suspension with the opportunity to request reinstatement after completion of the following stipulations:

a. Refrain from working in any capacity as a Registered Nurse. Failure to do so shall cause further disciplinary action and/or criminal charges.

b. Submit to outpatient evaluation, at Respondent's expense, at a Board-recognized evaluation center which shall include psychiatric, psychological, and substance abuse evaluations and testing as deemed appropriate by the evaluators based on Respondent's history. Respondent shall authorize and cause a written report of the said evaluation to be submitted to the Board. Respondent shall include the entire evaluation report including diagnosis, course of treatment, prescribed or recommended treatment, prognosis, and professional opinion as to Respondent's capability of practicing nursing with reasonable skill and safety to patients.

c. Submit all pages of the Louisiana Board's agreement to each evaluator prior to the start of the evaluations in order for the evaluation to be deemed valid.

d. Respondent consents to the release of the following by Louisiana Board staff to Respondent's above-described evaluators: Any and all information, documents and other records related to conditions, diagnoses and matters described in this document.

e. Immediately submit to all recommendations thereafter of the therapist, physician, or treatment team, and cause to have submitted evidence of continued compliance with all recommendations by the respective professionals. The Louisiana Board's stipulation shall continue until Respondent is fully discharged by the respective professionals and until approved

1 by the Louisiana Board's staff.

2 f. If the evaluations give any treatment recommendations or findings to warrant
3 concern for patient safety, Respondent shall meet with Louisiana Board or staff. Respondent
4 must demonstrate to the satisfaction of the Louisiana Board that Respondent poses no danger to
5 the practice of nursing or to the public and that Respondent can safely and competently perform
6 the duties of a registered nurse. If the Louisiana Board subsequently approves licensure, a period
7 of probation, along with supportive conditions or stipulations, will be required to ensure that
8 patients and the public are protected.

9 g. If diagnosed with chemical dependency or abuse of alcohol and/or other mood-
10 altering substances that has compromised or may compromise Respondent's capacity to practice
11 nursing with skill and safety, Respondent must immediately sign a Recovering Nurse Program
12 (RNP) agreement and cause to have submitted evidence of compliance with all program
13 requirements for a minimum of three (3) years. License suspension with stay and probation shall
14 be extended to run concurrently, on the same dates, with RNP participation.

15 h. Immediately (within 72 hours) inform the Louisiana Board in writing of any
16 change in address.

17 i. Submit written evidence of completion of 20 hours of Louisiana Board staff
18 approved continuing education hours in the area of Legal/Ethical Nursing Issues.

19 j. Submit payment of \$200.00 to the Louisiana Board as cost of the Consent
20 Order.

21 k. Submit payment of \$1,500.00 to the Louisiana Board in fines.

22 l. Not have any misconduct, criminal violation or convictions, or violations of any
23 health care regulations reported to the Louisiana Board related to this or other incidents.

24 m. Failure to comply with the above orders shall result in further disciplinary
25 action.

26 15. The circumstances of the Louisiana Board's Order are that on or about August 31,
27 2011, through September 20, 2011, while employed as a registered nurse at Healthsouth
28 Rehabilitation Hospital, in Alexandria, Louisiana, Respondent admitted that she medicated

1 patients with physician ordered Tylenol PM (with Benadryl) for the purpose of sedating and, in
2 effect, chemically restraining those patients for Respondent's convenience during her shift.

3 Respondent also made grossly incorrect, or grossly inconsistent entries in hospital patient records
4 in the following respects:

5 A. Patient 1¹

6 1. On or about August 31, 2011, at 7:54 p.m., Respondent removed Tylenol PM
7 for patient 1. Respondent documented administration on the Medication Administration Record
8 (MAR) at 8:00 p.m.

9 2. On or about September 1, 2011, at 9:22 p.m., Respondent removed Tylenol PM
10 for patient 1. Respondent failed to document the administration of Tylenol PM to patient 1 or
11 otherwise account for the wastage of the Tylenol PM.

12 B. Patient 2

13 1. On or about August 31, 2011, at 8:02 p.m., Respondent removed Tylenol PM
14 for patient 2. Respondent documented administration on the MAR at 8:00 p.m.

15 2. On or about September 1, 2011, at 9:29 p.m., Respondent removed Tylenol PM
16 for patient 2. Respondent documented administration on the MAR at 10:00 p.m.

17 3. On or about September 5, 2011, at 8:27 p.m., Respondent removed Tylenol PM
18 for patient 2. Respondent documented administration in the Nurses' Notes at 10:00 p.m.

19 C. Patient 3

20 1. On or about August 31, 2011, at 8:14 p.m., Respondent removed Tylenol PM
21 for patient 3. Respondent failed to document the administration of Tylenol PM to patient 3 or
22 otherwise account for the wastage of the Tylenol PM.

23 2. On or about September 5, 2011, at 8:12 p.m., Respondent removed Tylenol
24 PM for patient 3. Respondent documented administration on the MAR at 8:30 p.m.

25
26
27 ¹ Patient initials are used to protect the patient's privacy. Full names will be released to
28 Respondent in discovery.

1 D. Patient 4

2 1. On or about August 31, 2011, at 8:24 p.m., Respondent removed Tylenol PM
3 for patient 4. Respondent documented administration on the MAR at 8:30 p.m.

4 E. Patient 5

5 1. On or about August 31, 2011, at 8:43 p.m., Respondent removed Tylenol PM
6 for patient 5. Respondent documented administration on the MAR at 8:50 p.m.

7 F. Patient 6

8 1. On or about August 31, 2011, at 8:57 p.m., Respondent removed Tylenol PM
9 for patient 6. Respondent documented administration on the MAR at 8:50 p.m.

10 2. On or about September 5, 2011, at 7:39 p.m., Respondent removed Tylenol
11 PM for patient 6. Respondent documented administration on the MAR at 8:00 p.m.

12 G. Patient 7

13 1. On or about August 31, 2011, at 9:42 p.m., Respondent removed Tylenol PM
14 for patient 7. Respondent documented administration on the MAR at 9:45 p.m.

15 H. Patient 8

16 1. On or about September 1, 2011, at 7:34 p.m., Respondent removed Tylenol
17 PM for patient 8. Respondent documented administration on the MAR at 8:00 p.m.

18 I. Patient 9

19 1. On or about September 1, 2011, at 7:52 p.m., Respondent removed Tylenol
20 PM for patient 9. Respondent documented administration on the MAR at 11:20 p.m.

21 J. Patient 10

22 1. On or about September 1, 2011, at 8:15 p.m., Respondent removed Tylenol
23 PM for patient 10. Respondent documented administration on the MAR at 8:00 p.m.

24 2. On or about September 5, 2011, at 7:58 p.m., Respondent removed Tylenol PM
25 for patient 10. Respondent documented administration on the MAR at 8:00 p.m.

26 3. On or about September 6, 2011, at 9:30 p.m., Respondent removed Tylenol
27 PM for patient 10. Respondent documented administration on the MAR at 9:30 p.m.

28

1 K. Patient 11
2 1. On or about September 1, 2011, at 8:30 p.m., Respondent removed Tylenol
3 PM for patient 11. Respondent documented administration on the MAR at 8:30 p.m.
4 L. Patient 12
5 1. On or about September 1, 2011, at 8:48 p.m., Respondent removed Tylenol
6 PM for patient 12. Respondent documented administration on the MAR at 8:45 p.m.
7 M. Patient 13
8 1. On or about September 1, 2011, at 9:16 p.m., Respondent removed Tylenol
9 PM for patient 13. Respondent documented administration on the MAR at 9:10 p.m.
10 N. Patient 14
11 1. On or about September 5, 2011, at 7:39 p.m., Respondent removed Tylenol
12 PM for patient 14. Respondent documented administration in the Nurses' Notes at 10:00 p.m.
13 O. Patient 15
14 1. On or about September 6, 2011, at 7:46 p.m., Respondent removed Tylenol
15 PM for patient 15. Respondent documented administration on the MAR at 8:00 p.m.
16 P. Patient 16
17 1. On or about September 6, 2011, at 7:58 p.m., Respondent removed Tylenol
18 PM for patient 16. Respondent documented administration on the MAR at 8:00 p.m.
19 Q. Patient 17
20 1. On or about September 6, 2011, at 8:12 p.m., Respondent removed Tylenol
21 PM for patient 17. Respondent documented administration on the MAR at 8:00 p.m.
22 R. Patient 18
23 1. On or about September 6, 2011, at 8:40 p.m., Respondent removed Tylenol
24 PM for patient 18. Respondent documented administration on the MAR at 8:30 p.m.
25 S. Patient 19
26 1. On or about September 6, 2011, at 9:30 p.m., Respondent removed Tylenol
27 PM for patient 19. Respondent documented administration on the MAR at 9:30 p.m.
28 2. On or about September 9, 2011, at 8:59 p.m., Respondent removed Tylenol

1 PM for patient 19. Respondent documented administration on the MAR at 9:00 p.m.

2 3. On or about September 10, 2011, at 8:27 p.m., Respondent removed Tylenol

3 PM for patient 19. Respondent documented administration on the MAR at 8:30 p.m.

4 T. Patient 21

5 1. On or about September 6, 2011, at 9:55 p.m., Respondent removed Tylenol

6 PM for patient 21. Respondent documented administration on the MAR at 10:00 p.m.

7 U. Patient 22

8 1. On or about September 9, 2011, at 7:43 p.m., Respondent removed Tylenol

9 PM for patient 22. Respondent documented administration on the MAR at 8:00 p.m.

10 2. On or about September 10, 2011, at 10:43 p.m., Respondent removed Tylenol

11 PM for patient 22. Respondent did not document the administration or otherwise account for the
12 wastage of the Tylenol PM.

13 V. Patient 23

14 1. On or about September 9, 2011, at 8:08 p.m., Respondent removed Tylenol

15 PM for patient 23. Respondent documented administration on the MAR at 8:00 p.m.

16 2. On or about September 10, 2011, at 8:33 p.m., Respondent removed Tylenol

17 PM for patient 23. Respondent documented administration on the MAR at 8:45 p.m.

18 W. Patient 24

19 1. On or about September 9, 2011, at 8:19 p.m., Respondent removed Tylenol

20 PM for patient 24. Respondent documented administration on the MAR at 8:00 p.m.

21 2. On or about September 10, 2011, at 8:05 p.m., Respondent removed Tylenol

22 PM for patient 24. Respondent documented administration on the MAR at 5:50 a.m.

23 X. Patient 25

24 1. On or about September 9, 2011, at 8:29 p.m., Respondent removed Tylenol

25 PM for patient 25. Respondent documented administration in the Nurses' Notes at 10:00 p.m.

26 2. On or about September 10, 2011, at 8:45 p.m., Respondent removed Tylenol

27 PM for patient 25. Respondent documented administration in the Nurses' Notes at 8:45 p.m.

1 Y. Patient 26

2 1. On or about September 10, 2011, Respondent repeatedly attempted to persuade
3 patient 26, against his wishes to take Tylenol PM. Patient 26 complained to Respondent's
4 supervisor the next day.

5 2. On or about September 10, 2011, at 9:10 p.m., Respondent removed 10 mg of
6 Percocet for patient 26. Respondent documented administration of the Percocet at 8:30 p.m.
7 Respondent did not actually administer the Percocet to patient 26 because the patient refused it.
8 Respondent failed to account for the wastage of the 10 mg of Percocet.

9 3. On or about September 10, 2011, at 6:00 a.m., Respondent documented that
10 patient 26 had no complaints of pain. Respondent removed 10 mg of Percocet for patient 26 at
11 6:12 a.m. Respondent documented administration of the Percocet at 4:10 a.m. Respondent did
12 not actually administer the Percocet to patient 26. Respondent failed to account for the wastage
13 of the 10 mg of Percocet.

14 Z. Patient 27

15 1. On or about September 14, 2011, Respondent removed Tylenol PM for patient
16 27, when that medication had been discontinued on or about September 13, 2011. Respondent
17 failed to document the administration or otherwise account for the wastage of the Tylenol PM.

18 AA. Patient 28

19 1. On or about September 14, 2011, at 10:48 p.m., Respondent removed Tylenol
20 PM for patient 28. Respondent documented administration on the MAR at 10:30 p.m.

21 BB. Patient 29

22 1. On or about September 14, 2011, at 9:28 p.m., Respondent removed Tylenol
23 PM for patient 29. Respondent failed to document the administration or otherwise account for the
24 wastage of the Tylenol PM.

25 CC. Patient 30

26 1. On or about September 14, 2011, at 9:36 p.m., and again at 9:43 p.m.,
27 Respondent removed Tylenol PM for patient 30. Respondent documented the administration of
28 one dose of Tylenol P.M. at 9:30 p.m. Respondent failed to document the administration or

otherwise account for the wastage of the remaining dose of Tylenol PM.

DD. Patient 31

1. On or about September 14, 2011, at 10:41 p.m., Respondent removed Tylenol PM for patient 31. Respondent documented the administration on the MAR at 10:30 p.m. Respondent documented the administration of a second dose of Tylenol PM at 6:00 a.m.

EE. Patient 32

1. On or about September 14, 2011 at 11:09 p.m., Respondent removed Tylenol PM for patient 32. Respondent documented the administration on the MAR at 11:00 p.m.

FF. Patient 33

1. On or about September 14, 2011, at 9:16 p.m., Respondent removed two 25 mg tablets of Chlordiazepoxide for patient 33. Respondent documented the administration at 8:00 p.m. Respondent removed an additional two 25 mg tablets of Chlordiazepoxide for patient 33 at 9:42 p.m., when there were no doctor's orders for the additional withdrawal. Respondent failed to document the administration or otherwise account for the wastage of the second withdrawal of the two 25 mg tablets of Chlordiazepoxide.

16. On or about the following dates and earlier than the charting incidents described in paragraph 15, above, Respondent demonstrated failure to maintain minimal standards of nursing practice as follows:

a. Respondent failed to update most of the patient care plans and demonstrated only sketchy patient education documentation. On June 1, 2011, Respondent received a written warning for poor performance related to the tasks of patient education, documentation of patient education, and updating plans of care. Agency was preparing for a stroke certification survey and audited thirty-five cerebrovascular patient records, and discovered that Respondent failed to update most of the care plans and demonstrated only sketchy patient education documentation.

b. Respondent failed to consistently complete Braden scale documentation on the weekly plans of care. On July 22, 2011, Respondent received a verbal counseling for, as discovered by internal auditors, failing to consistently complete Braden scale on the weekly Plan of Care updates. This issue was previously addressed on June 1, 2011.

1 c. Respondent failed to lock the work computer as directed. On July 22, 2011,
2 Respondent received a verbal counseling for leaving the back computer at the third floor nurses'
3 station unlocked and at risk for breach of patient confidentiality.

4 d. Respondent failed to timely complete chart documentation after working the
5 night shift of September 14, 2011.

6 **SECOND CAUSE FOR DISCIPLINE**

7 **(Grossly Incorrect and/or Grossly Inconsistent Entries in Patient Records)**

8 17. Respondent has subjected her license to disciplinary action under Code section 2761,
9 subdivision (a) on the grounds of unprofessional conduct, as defined in section 2762, subdivision
10 (e), based on the acts and/or omissions set forth in paragraph 15, above.

11 **THIRD CAUSE FOR DISCIPLINE**

12 **(Unprofessional Conduct – Unlawfully Obtained Controlled Substances)**

13 18. Respondent has subjected her license to disciplinary action under Code section 2761,
14 subdivision (a), and 2762, subdivision (a), because she unlawfully obtained controlled substances.
15 The circumstances are described above in paragraph 15.

16 **PRAYER**

17 WHEREFORE, Complainant requests that a hearing be held on the matters alleged in this
18 Accusation, and that following the hearing, the Board of Registered Nursing issue a decision:

19 1. Revoking or suspending Registered Nurse License Number 576212, issued to Sharon
20 Barstow, aka Sharon Grant Barstow;

21 2. Ordering Sharon Barstow, aka Sharon Grant Barstow to pay the Board of Registered
22 Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to
23 Business and Professions Code section 125.3;

24 3. Taking such other and further action as deemed necessary and proper.

25 DATED: March 27, 2013

26 *Louise R. Bailey*
LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant